DEPARTMENT OF DEFENSE
NONAPPROPRIATED FUND HEALTH BENEFITS PROGRAM

Summary of Benefits

Open Choice® PPO Plan

Effective January 1, 2006

Plan Provisions	Open Choice PPO Benefits Preferred Care Benefits (In-Network)	Non-Preferred Care Benefits (Out-of-Network)
Calendar Year Deductible		
★ Individual	$200	$ 600
★ Family	$600 (3 times individual)	$1,800 (3 times individual)
Out-of-Pocket Limit (the maximum amount you pay for your share of covered expenses in a calendar year. Copays, confinement fees, expenses covered at 50% and non-covered expenses do not count toward your Out-of-Pocket Limit)		
★ Individual	$3,000	$ 4,000
★ Family	$9,000 (3 times individual)	$12,000 (3 times individual)
Lifetime Maximum	Unlimited	Unlimited
Precertification Certain services require precertification. Please see your Summary Plan Description (SPD) for details.	Network physician handles	You handle; $500 penalty for failure to precertify
Preventive Care Deductible is waived for preventive care services		
★ Routine physical exam and immunizations (one per calendar year)	100%, no copay	Not covered
★ Well-child care and immunizations Birth to age 7. Please see your SPD for age and frequency schedule.	100%, no copay	Not covered
★ Routine gynecological exam including Pap test and related lab fees (one per calendar year)	100%, no copay	Not covered
★ Routine Mammogram (one per calendar year for women age 35 and over)	100%, no copay	Not covered
★ Routine prostate screening exam (one per calendar year for men age 40 and over)	100%, no copay	Not covered
★ Routine eye exam (one per calendar year)	100%, no copay	Not covered
★ Prescription eyewear - lenses, frames and contacts (in addition to Vision One® Discount Program)	100%, no copay, up to a $150 maximum benefit per person per calendar year	100%, up to a $150 maximum benefit benefit per person per calendar year
★ Routine hearing exam (one per calendar year)	100%, no copay	Not covered
★ Hearing aids ($1,000 lifetime maximum)	100%, no copay	100%
Physician Services		
★ Office visits for treatment of illness or injury	100% after copay: $15 PCP*/ $35 specialist; no deductible	60% after deductible
★ Diagnostic lab and X-ray	100%, no additional copay when part of an office visit; otherwise 100% after copay: $15 PCP*/ $35 specialist; no deductible	60% after deductible
★ Maternity care office visits	100% after copay: $15 PCP*/ $35 specialist for first visit; subsequent visits are included in the delivery fee and paid at 90% after deductible	60% after deductible
★ In-office surgery	100% after copay: $15 PCP*/ $35 specialist; no deductible	60% after deductible
★ Physician hospital visits	90% after deductible	60% after deductible
★ Anesthesia	90% after deductible	60% after deductible
★ Allergy testing, serum and injections	100% after copay: $15 PCP*/ $35 specialist when part of office visit; otherwise 100% no copay, no deductible	60% after deductible
★ Second surgical opinion	100%, no copay, no deductible	100%, no deductible
Hospital Services		
★ Inpatient hospital room and board and ancillary services	90% after deductible plus $200 per confinement fee*	60% after deductible plus $400 per confinement fee*
★ Inpatient and outpatient surgery	90% after deductible	60% after deductible
★ Outpatient services	90% after deductible	60% after deductible
★ Pre-operative testing	90%, no deductible	60%, no deductible
★ Other hospital services	90% after deductible	60% after deductible

* *A Primary Care Physician (PCP) can be an internist, pediatrician, family practitioner or general practitioner. A provider who does not meet this definition is considered a specialist.*

* *Hospital confinement fee is waived for newborns and subsequent hospital confinements for the same condition within the same calendar year.*

DoD OC 05-0265 09/2005

Summary of Benefits

Effective January 1, 2006

continued

Plan Provisions	Open Choice PPO Benefits Preferred Care Benefits (In-Network)	Non-Preferred Care Benefits (Out-of-Network)
Emergency Care		
★ Hospital emergency room	100% after $150 emergency room copay (waived if admitted); no calendar year deductible	100% after separate $150 emergency room deductible (waived if admitted); no calendar year deductible
★ Hospital emergency room for non-emergency care	50% after deductible plus $150 emergency room copay	50% after deductible plus separate $150 emergency room deductible
★ Ambulance	80%, after deductible	80% after deductible
Other Health Care		
★ Convalescent facility (up to 90 days per calendar year)	90% after deductible	60% after deductible
★ Home health care (up to 90 visits per calendar year)	90% after deductible	60% after deductible
★ Private duty nursing (up to 70 eight-hour shifts per calendar year)	90% after deductible	60% after deductible
★ Hospice (inpatient and outpatient)	100%, no copay, no deductible	100%, no deductible
★ Independent lab and X-ray facilities	90% after deductible	60% after deductible
★ Voluntary sterilization	100% after $100 copay; no deductible	60% after deductible
★ Short-term rehabilitation (60-day maximum per course of treatment)	80% after deductible	80% after deductible
★ Durable medical equipment	80% after deductible	80%, after deductible
★ Spinal disorder (chiropractic) (20 visits per calendar year)	100% after copay: $15 PCP/$35 specialist; no deductible	60% after deductible
★ Bariatric surgery	50% after deductible	50% after deductible
Mental Health Care*		
★ Inpatient (no maximum on number of days)	80% after deductible plus $200 inpatient per confinement fee	60% after deductible plus $400 inpatient per confinement fee
★ Outpatient (up to 45 visits per calendar year)	100% after $35 copay per visit; no deductible	60% after deductible
* *Outpatient day maximums for Mental Health and Substance Abuse are not combined. However, Preferred and Non-Preferred limits are combined.*		
Substance Abuse Treatment*		
★ Inpatient (up to 45 days per calendar year)	80% after deductible plus $200 inpatient per confinement fee	60% after deductible plus $400 per confinement fee
★ Outpatient (up to 45 visits per calendar year)	100% after $35 copay per visit; no deductible	60% after deductible
* *Outpatient day maximums for Mental Health and Substance Abuse are not combined. However, Preferred and Non-Preferred limits are combined.*		
Prescription Drug Benefits		
Participating Retail Pharmacy Program (up to a 30-day supply purchased at a local participating pharmacy)	*Participating Pharmacy*	*Non-Participating Pharmacy*
★ Generic drugs	100% after $10 copay	Not covered
★ Formulary brand-name drugs	100% after $25 copay	Not covered
★ Non-formulary brand-name drugs	100% after $35 copay	Not covered
Prescriptions Purchased Overseas		
★ Generic drugs	Not applicable	100% after deductible
★ Brand-name drugs	Not applicable	80% after deductible
Mail-Order Service (up to a 90-day supply)		
★ Generic drugs	100% after $20 copay	Not applicable
★ Formulary brand-name drugs	100% after $40 copay	Not applicable
★ Non-formulary brand-name drugs	100% after $60 copay	Not applicable

Covered dependents who live outside the Open Choice network area will receive the Traditional Choice® indemnity plan level of benefits. Please see your Human Resources Representative for details. This chart displays only a general description of your benefits under the DOD NAF HBP. Should there be a conflict between the benefits shown on the chart and those in the Summary Plan Description (SPD), the terms of the SPD will be used to determine coverages and benefits.

DoD OC 05-0265 09/2005